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BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

In the Matter of CONNECTICUT GENERAL LIFE INSURANCE COMPANY Respondent.	File No. OSC-2012-00010 **ORDER TO SHOW CAUSE AND STATEMENT OF CHARGES** **(California Insurance Code §§ 790.03, 700(c), and 790.035)**

ORDER TO SHOW CAUSE

WHEREAS, the Insurance Commissioner of the State of California (hereafter, "the Commissioner") has reason to believe that Connecticut General Life Insurance Company (hereinafter "Respondent") has engaged in or is engaging in this State in unfair methods of competition or unfair or deceptive acts or practices set forth in the STATEMENT OF CHARGES contained herein, in violation of Sections 790 et seq. of the California Insurance Code and the Fair Claims Settlement Regulations of Title 10, Chapter 5, California Code of Regulations; and

WHEREAS, the Commissioner has reason to believe that RESPONDENT has engaged in conduct in violation of California's Mental Health Parity Act, CIC Section 10144.5; and

WHEREAS, the Commissioner believes that a proceeding with respect to the alleged acts of RESPONDENT would be in the public interest;

NOW, THEREFORE, and pursuant to the provisions of CIC Sections 790.05,

RESPONDENT is ordered to appear before the Commissioner on a date to be determined and show cause, if any cause there be, why the Commissioner should not issue an Order requiring RESPONDENT to Cease and Desist from engaging in the acts and practices set forth in the STATEMENT OF CHARGES contained herein and imposing the penalties set forth in Section 790.035 of the Insurance Code and other Insurance Code sections as requested herein

JURISDICTION AND PARTIES

1. The California Department of Insurance (hereafter "Department") brings this matter before the Commissioner pursuant to the provisions of Insurance Code § 790.05.

2. Respondent is, and at all relevant times has been, the holder of a Certificate of Authority issued by the Commissioner and is authorized to transact the business of insurance in California.

STATUTES AND REGULATIONS

3. Insurance Code § 790.03(h) enumerates sixteen (16) claims settlement practices that, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices, and are thus prohibited.

4. Insurance Code § 790.03(h)(1) prohibits insurers from misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages contained in the contract.

5. Insurance Code § 790.03(h)(5) requires that insurers exercise good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

6. Insurance Code § 790.035 provides that "any person who engages in any unfair method of competition or any unfair or deceptive act or practice defined in § 790.03 is liable to the state for a civil penalty to be fixed by the Commissioner, not to exceed five thousand dollars ($5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act. The Commissioner shall have the discretion to establish what constitutes an act."

7. Insurance Code § 10123.13(a) requires that "[e]very insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, including those

telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the Department of a claim that the insurer contested or denied, and the notice shall include the address, Internet Web site address, and telephone number of the unit within the Department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Insurance Code § 10123.137. The notice to the insured may also be included on the explanation of benefits."

8. Insurance Code § 10144.5, California's Mental Health Parity Act (hereafter "MHPA"), provides as follows:

> (a) Every policy of disability insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after July 1, 2000, shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same

terms and conditions applied to other medical conditions, as specified in subdivision (c).

(b) These benefits shall include the following:

(1) Outpatient services.

(2) Inpatient hospital services.

(3) Partial hospital services.

(4) Prescription drugs, if the policy or contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section that shall be applied equally to all benefits under the disability insurance policy shall include, but not be limited to, the following:

(1) Maximum lifetime benefits.

(2) Copayments and coinsurance.

(3) Individual and family deductibles.

(d) For the purposes of this section, "severe mental illnesses" shall include:

(1) Schizophrenia.

(2) Schizoaffective disorder.

(3) Bipolar disorder (manic-depressive illness).

(4) Major depressive disorders.

(5) Panic disorder.

(6) Obsessive-compulsive disorder.

(7) Pervasive developmental disorder or autism.

(8) Anorexia nervosa.

(9) Bulimia nervosa.

9. Insurance Code § 10169.3(f) provides that "[t]he commissioner shall immediately adopt the determination of the independent medical review organization, and shall promptly issue a written decision to the parties that shall be binding on the insurer."

10. California Code of Regulations ("CCR"), Title 10, Chapter 5, Subchapter 7.5,

Article 1 contains the Fair Claims Settlement Practices Regulations "to promote the good faith, prompt, efficient and equitable settlement of claims." These regulations delineate certain minimum standards for the settlement of claims which, when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice, shall constitute an unfair claims settlement practice within the meaning of Insurance Code § 790.03(h). Other acts or practices not specifically delineated in this set of regulations may also be unfair claims settlement practices subject to Insurance Code § 790.03. All licensees are required to have thorough knowledge of such regulations.

11. CCR, Title 10, § 2695.5(b) provides that "[u]pon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

12. CCR, Title 10, § 2240(a)(7) defines basic health care services:

> (a) "Basic health care services" means any of the following covered health care services provided for in the applicable insurance contract or certificate of coverage:
>
> (1) Physician services, including consultation and referral.
>
> (2) Hospital inpatient services and ambulatory care services.
>
> (3) Diagnostic laboratory diagnostic and therapeutic radiologic services.
>
> (4) Home health services.
>
> (5) Preventive health services.
>
> (6) Emergency health care services, including ambulance services.
>
> (7) Mental health care services including those intended to meet the requirements of Insurance Code 10144.5.
>
> (8) Any other health care or supportive services that are covered pursuant to an insurance contract.

13. CCR, Title 10, § 2240.1 addresses the adequacy and accessibility of providers required in an insurer's network:

> (c) In arranging for network provider services, insurers shall ensure that:
>
> (1) There is the equivalent of at least one full-time physician per 1,200 covered persons and at least the equivalent of one full-time primary care physician per 2,000 covered persons.
>
> (2) There are primary care network providers with sufficient capacity to accept covered persons within 30 minutes or 15 miles of each covered person's residence or workplace.
>
> (3) There are medically required network specialists who are certified or eligible for certification by the appropriate specialty board with sufficient capacity to accept covered persons within 60 minutes or 30 miles of a covered person's residence or workplace. Notwithstanding the above, the Commissioner may determine that certain medical needs require network specialty care located closer to covered persons when the nature and frequency of use of such health care services, and the standards of Insurance Code 10133.5(b) (3), support such modification.
>
> (4) There are mental health professionals with skills appropriate to care for the mental health needs of covered persons and with sufficient capacity to accept covered persons within 30 minutes or 15 miles of a covered person's residence or workplace.

14. Insurance Code § 10169(d)(3) provides that "[t]he Department shall be the final arbiter when there is a question as to whether an insured grievance is a disputed health care service or a coverage decision… If there appears to be any medical necessity issue, the grievance shall be resolved pursuant to an independent medical review as provided under this article."

BACKGROUND

15. On a number of occasions in 2010 and 2011, Respondent denied coverage for

ABA Therapy, asserting that ABA Therapy was not covered because it is an experimental and investigational treatment. The families appealed these denials through an Independent Medical Review (IMR) process, and in every case the denial was reversed.

In each case, the doctors who conducted the IMR found that the prescribed ABA Therapy was medically necessary. As required by law, the Commissioner immediately adopted the IMR Decisions and immediately notified Respondent, and requested that the medically necessary services be covered. Ultimately, the ABA Therapy was covered by Respondent.

STATEMENT OF CHARGES

A. Improper Denial of Coverage on the Ground ABA Therapy Is "Experimental"

16. During 2010 and 2011, Respondent denied coverage for ABA Therapy on the grounds that ABA Therapy was an experimental, investigational and unproven treatment in violation of § 790.03(h)(1) and §10144.5(a).

17. Section 790.03(h)(1) prohibits insurers from misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverage contained in the contract. Respondent misrepresented a pertinent fact when it claimed that ABA Therapy was an experimental, investigational and unproven treatment. Misrepresenting ABA Therapy as experimental enabled Respondent to deny coverage for ABA Therapy pursuant to its contract, which does not cover experimental treatments.

18. Respondent also violated §10144.5(a), California's Mental Health Parity Act, which provides that insurance policies shall cover medically necessary treatment of severe mental illnesses under the same terms and conditions applied to other medical conditions; §10144.05(a) specifies that "pervasive developmental disorder or autism" is a "severe mental illness." Pediatricians prescribed ABA Therapy as medically necessary for the treatment of autism, which is a severe mental illness under the statute. Therefore, the Act requires that Respondent cover ABA Therapy; Respondent nonetheless denied coverage in violation of §10144.5(a).

B. Failure to Provide In-Network Behavioral Intervention Therapy Providers As Required by Provider Network Access Regulations

19. Title 10 CCR § 2240(a)(7) and § 2240.1(c)(4) require that an insurer's network provide access to mental health professionals with skills appropriate to care for the mental health needs of covered persons and with sufficient capacity to accept covered persons within 30 minutes or 15 miles of a covered person's residence or workplace.

20. On June 3, 2011, the Department issued a request to Respondent for a listing of the in-network Behavioral Intervention Therapy providers accessible to its insureds with PPO health insurance coverage.

21. On June 24, 2011 Respondent replied to the Department's data request. In its reply Respondent admitted that it could not ensure that its network provides adequate access to Behavioral Intervention Therapy providers to all of its insured customers.

22. By failing to ensure that their network adequately provides coverage to all of their insured customers in California, Respondent is in violation of 10 CCR § 2240(a)(7) and § 2240.1(c)(4).

C. Denial of Treatment in Violation of Mental Health Parity by Failing to Provide Access to Behavioral Intervention Therapy Providers.

23. Insurance Code § 10144.5, California's Mental Health Parity Act, requires that insurers provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses including autism.

24. In its response to the Department's data request on Behavioral Intervention Therapists, the Respondent failed to ensure that there is an adequate network of Behavioral Intervention Therapy Providers available to their insureds.

25. Respondent could not guarantee that access was available to a Provider capable of providing adequate treatment to all of its insureds. By failing to ensure that all of their insureds have access to a Behavioral Intervention Therapy provider capable of providing adequate treatment, Respondent is in violation of Insurance Code § 10144.5.

STATEMENT OF GROUNDS FOR MONETARY PENALTY AND POTENTIAL LIABILITY PURSUANT TO CIC §§790 *et seq*

26. The facts alleged above in Paragraphs 16 through 25 constitute grounds, under § 790.05, for the Insurance Commissioner to order Respondent to cease and desist from engaging in such unfair acts or practices and to pay a civil penalty not to exceed five thousand dollars ($5,000) for each act, or if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act as set forth under § 790.035 .

REQUEST FOR ORDER AND MONETARY PENALTY

WHEREFORE, Petitioner prays for judgment against Respondent as follows:

1. An Order to Cease and Desist from engaging in the methods, acts, and practices set forth in the STATEMENT OF CHARGES as set forth above;

2. For acts in violation of Insurance Code Section 790.03 and the regulations promulgated pursuant to Section 790.10 of the Insurance Code, as set forth above, a civil penalty not to exceed five thousand dollars ($5,000) for each act or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act;

3. Full restitution or reimbursement for acts or omissions in violation of the above-cited provisions of law; and,

4. Costs incurred by the Department in bringing this action and any future costs to the Department to ensure compliance.

CALIFORNIA DEPARTMENT OF INSURANCE

Dated: February 23, 2012

By ___/s/_____
Teresa R. Campbell
Assistant Chief Counsel